U.S. Department of Labor

Office of Administrative Law Judges
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

(856) 486-3800
(856) 486-3806 (FAX)

Issue Date: 20 April 2007

Case No.: 2005-BLA-05807

In the Matter of

R. G.
Claimant

v.

U. S. STEEL MINING COMPANY, LLC
Employer/Self-Insured

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances: PATRICK NAKAMURA, Esq. For the Claimant
JAMES NOLAN, Esq. For the Employer

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On April 21, 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing (DX 43).[1] Subsequently, on May 4, 2006, the case was assigned to me. The hearing was held before me in Birmingham, Alabama on September 28, 2006, at which time the parties had full opportunity to present evidence and argument.[2]

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issues are presented for adjudication:

(1) whether the evidence establishes a change in condition or a mistake in determination of fact;
(2) whether the Claimant suffers from pneumoconiosis;
(3) whether his pneumoconiosis, if any, arose from coal mine employment;
(4) whether the Claimant is totally disabled; and
(5) whether the Claimant's total disability, if any, is due to pneumoconiosis.

II. PROCEDURAL BACKGROUND

This claim represents a request for modification of a subsequent claim. The Claimant filed his prior claim on February 18, 1997. On May 30, 1997, the District Director denied that claim, after finding that the evidence did not establish pneumoconiosis arising out of coal mine employment, and did not show total disability due to pneumoconiosis.

The Claimant filed this claim for benefits on July 5, 2002 (DX 3). On May 19, 2003, the District Director issued a proposed Decision and Order denying benefits to the Claimant (DX 20).[3] The Claimant requested a formal hearing in a letter dated June 16, 2003 (DX 22). On August 26, 2003, the matter was referred to the Office of Administrative Law Judges ("OALJ"), and subsequently assigned to Administrative Law Judge ("ALJ") Gerald M. Tierney (EX 25). On September 13, 2004, ALJ Tierney issued his Decision and Order awarding benefits to the Claimant (DX 35).

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[1] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T." refers to the transcript of the September 28, 2006 hearing.

[2] The Claimant did not testify at the hearing. However, the record does contain the Claimant's testimony before ALJ Tierney.

[3] The record includes a copy of a proposed Decision and Order written by the Director on February 24, 2003 (DX 18). The record also includes a letter that the Director wrote to Claimant's counsel on May 19, 2003, in which the Director explains that the proposed Decision and Order was dated February 24, 2003, but the Director "failed to forward a copy to [his] office." Based on this correspondence, I do not consider the proposed Decision and Order to have been issued until it was sent to the Claimant's counsel. See DX 20.

In a letter dated October 25, 2004, the Employer submitted to the Director its request for modification requesting reconsideration "because of a change in conditions or because of a mistake in determination of fact," but cited no specifics (DX 36). In January 2005, the Employer submitted Dr. Rosenberg's report (DX 38). On March 2, 2005, the Director issued its proposed Decision and Order denying the Employer's request for modification (DX 39). In a letter dated March 24, 2005, the Employer made a Motion for reconsideration (DX 40), and on April 1, 2005, the Director issued its proposed Decision and Order denying the Employer's request for modification, stating that "Dr. Rosenberg's report is insufficient to establish a change in condition or an error in a finding of fact in the Decision and Order Awarding Benefits" (DX 41). In a letter dated April 7, 2005, the Employer appealed the Director's proposed Decision and Order (DX 42), and the matter was again referred to OALJ for a formal hearing (DX 43).[4]

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant was born in July of 1936. He currently has no dependents (DX 3). The Claimant worked in coal production for 18 years, and held positions in repair, as an electrician and mechanic, as well as doing general labor (DX 8). His coal mine employment ended in 1994 (DX 8).

B. Relevant Medical Evidence

The evidence initially presented to ALJ Tierney was again presented to me. The Employer presented the medical opinion from Dr. Hasson that it submitted in the proceeding before ALJ Tierney, which included a chest X-ray interpretation, a pulmonary function test, and a blood gas study (EX 1). The Claimant presented evidence that was also submitted to ALJ Tierney, specifically a chest X-ray interpretation performed by Dr. Ahmed, along with his curriculum vitae (DX 31), a blood gas study performed by Dr. Hasson (EX 1), and an additional letter from Dr. Hawkins (DX 31). The OWCP evaluation was performed by Dr. Hawkins, which included a pulmonary function study and a blood gas study; however, Dr. Ballard performed the chest X-ray interpretation (DX 10).

As new evidence presented upon request for modification, the Employer submitted a medical opinion from Dr. Rosenberg, along with his curriculum vitae (EX 2, 3), as well as the results of a medical examination performed by Dr. Goldstein, which included a chest X-ray

[4] The Employer's post-hearing brief asserted a mistake in determination of fact made in this claim; the mistake concerned Dr. Rosenberg's report (DX 38), which was submitted as new evidence before the Director upon request for modification. In the brief, the Employer stated that the "reconsideration request was brought to address … [the District Director's] fundamental mistake." Specifically, the Employer alleges that, while considering the modification request, the District Director discounted its opining physician, Dr. Rosenberg, because the District Director found that Dr. Rosenberg "failed to elaborate on what caused the [Claimant's] disability;" Employer alleged that Dr. Rosenberg did "clearly and unequivocally identif[y] the cause of the abnormality." Employer's Brief at 5.

interpretation, pulmonary function test, blood gas study, and Dr. Goldstein's curriculum vitae (EX 4, 5). After the hearing, the Claimant submitted the following new evidence: an X-ray interpretation performed by Dr. Miller (CX 3), a rehabilitative report by Dr. Hawkins (CX 4), and an affidavit by the Claimant [5] (CX 5).

These items will be discussed in greater detail below.

C. Entitlement

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. § 718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

Further, as stated above, this proceeding is a request for modification of a subsequent claim. § 725.310. The amended regulations at § 725.310(c) provide that "[i]n any case forwarded for hearing, the administrative law judge assigned to hear such case shall consider whether any additional evidence submitted by the parties demonstrates a change in condition and, regardless of whether the parties have submitted new evidence, whether the evidence of record demonstrates a mistake in a determination of fact."

In determining whether a "change in conditions" is established, the fact-finder must conduct an assessment of the newly submitted evidence (all evidence submitted subsequent to the prior adjudication) and consider it in conjunction with the previously submitted evidence to determine if the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated. See Kingery v. Hunt Branch Coal Co., 19 B.L.R. 1-6 (1994). Even if a "change in conditions" is not established, evidence in the entire claim file must be considered to determine whether a "mistake in a determination of fact" was made. This is required even where no specific mistake of fact has been alleged. Kingery, supra. Moreover, a mistake of fact may be "demonstrated by wholly new evidence, cumulative evidence, or merely

[5] The Claimant did not appear at the hearing as he was misinformed of the time of the hearing, therefore, I left the record open to allow him to submit an affidavit concerning the current state of his breathing and the medication he takes (T. at 5-8). His affidavit relates that he is taking several prescription medications for his breathing, including Advair, Spiriva, Duo-Neb, and Albuterol, and that he has a "yellow mucous, (sic) usually after taking [his] morning medicine." He stated the following: "I spend my days primarily sitting and watching television…. I do try to walk in the morning, but I have to stop and sit about every 40 yards because I get out of breath. Any kind of increased activity seems to get me more short of breath and makes me feel weak." He also stated: "I will go fishing on occasion but go to places where I can drive close to the bank. I do cook, but any chores or cleaning are done [by] my family members" (CX 5).

further reflection on the evidence initially submitted." Zurat v. Director, OWCP, No. 98-1075 BLA (BRB: May 4, 1999).[6]

Specific limitations govern the submission of evidence on modification. Upon a request for modification, the parties are entitled to submit the evidence permitted under § 725.414, as well as additional evidence permitted under § 725.310. The Benefits Review Board recently held that these two provisions "should be read together to establish combined evidentiary limits on modification, to allow a party to submit for the first time in a modification proceeding all of the evidence permitted by each regulation…. Consequently, 20 C.F.R. §§ 725.414 and 725.310(b) apply together in modification proceedings on a claim." Rose v. Buffalo Mining Co., No. 06-0207 BLA, at 6 (BRB: Jan. 31, 2007). Based on this precedent, I find that neither party has exceeded the evidentiary limitations of § 725.414 in this matter.

1. Decision and Order of ALJ Tierney

In the prior decision in this claim, ALJ Tierney examined several pieces of evidence, which he found established all of the elements of entitlement, and thus awarded benefits to the Claimant (DX 35).

On the question of the existence of pneumoconiosis, ALJ Tierney examined two interpretations of a chest X-ray taken on August 27, 2002 by Dr. Ballard and Dr. Ahmed; both physicians are dually qualified as B readers and Board certified radiologists, and both read the film as 1/0 positive for pneumoconiosis. ALJ Tierney also examined an interpretation of an X-ray taken on March 10, 2004, performed by Dr. Hasson, a B reader, who read the film as 0/0 negative for pneumoconiosis.[7] On the basis of chest X-ray evidence, ALJ Tierney found that the Claimant established the existence of pneumoconiosis. ALJ Tierney also found that the Claimant established the existence of pneumoconiosis on the basis of new biopsy evidence, specifically, a pathology report that identified anthracosilicotic nodules. Therefore, ALJ Tierney found that the Claimant established a change in a condition of entitlement, which triggered a review of the entire record as this was a subsequent claim. See § 725.309.

On the question of whether the Claimant's pneumoconiosis arose out of coal mine employment, ALJ Tierney found that such causation was presumed, and that the Employer did not present evidence sufficient to rebut the presumption.

On the question of disability, ALJ Tierney found that the Claimant did not establish total disability by pulmonary function studies, by arterial blood gas studies, or by cor pulmonale with right-sided congestive heart failure. However, ALJ Tierney did find that the Claimant established total disability on the basis of physician opinion; ALJ Tierney examined the opinions of Dr. Hawkins and Dr. Hasson. In particular, he relied on the opinion of Dr. Hawkins, who

[6] The Employer never alleged any specific mistake of fact by ALJ Tierney. In its request for reconsideration, the Employer asserted that Dr. Rosenberg attributed the Claimant's disability to his smoking history.

[7] After a search of the record, I was unable to locate a B reading performed by Dr. Hasson. I did, however, find a narrative description of an X-ray in his written opinion report (DX 29).

reported that the Claimant had pneumoconiosis from coal dust exposure, and that he did not have the respiratory capacity to perform his last coal mine job of electrician/repairman. On the OWCP evaluation form, Dr. Hawkins attributed the Claimant's disability as follows: 60% due to cardiomyopathy, and 40% due to coal dust exposure. In an additional opinion, which was made on a form given to Dr. Hawkins by Claimant's counsel that described Claimant's job duties, Dr. Hawkins checked an option which states that the Claimant "does not have the respiratory capacity to perform the job of electrician/repairman but I believe this impairment is caused by both other factors and exposure to coal and rock dust during his employment."[8] ALJ Tierney gave little weight to Dr. Hasson's opinion, because Dr. Hasson did not find evidence of pneumoconiosis, which ALJ Tierney found was contrary to the evidence of record, specifically the chest X-ray and biopsy evidence. ALJ Tierney stated that "Dr. Hasson was not aware that this evidence of pneumoconiosis existed." Therefore, ALJ Tierney relied on Dr. Hawkins' opinion to "find that pneumoconiosis is a substantially contributing cause of [the Claimant's] totally disabling respiratory or pulmonary impairment."

Upon review of the prior record, and further reflection of the evidence, I find that ALJ Tierney made a mistake in determination of fact when he found that "it can reasonably be inferred from Dr. Hawkins' report that he considered Claimant's pneumoconiosis or coal mine dust exposure as making more than a negligible, inconsequential, or insignificant contribution to Claimant's total disability." I find that such a finding cannot be reasonably inferred from Dr. Hawkins' opinion, which I found unclear, conclusory, and incomplete.

Even though the record indicates that Dr. Hawkins was aware of the Claimant's extensive smoking history, Dr. Hawkins did not address the impact of smoking on the Claimant's respiratory impairment in his opinion. However, rather than weigh Dr. Hawkins' conclusions in the light of this evidence, ALJ Tierney stated merely that: "Relying on the opinion of Dr. Hawkins, I find that the Claimant has proved, by a preponderance of evidence, that pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment" (DX 35 at 6).

Additionally, as ALJ Tierney's Decision reflects, Dr. Hasson found "no evidence" of pneumoconiosis. Dr. Hasson's conclusion that the Claimant had COPD was based on physical examination, pulmonary function test, and arterial blood gas results. This conclusion, and Dr. Hasson's opinion that the Claimant's condition was related to smoking, were reasonable, based on the fact that the evidence of record established clearly that the Claimant had a smoking history of 45-150 pack years.[9] However, ALJ Tierney discounted Dr. Hasson's opinion that the Claimant had chronic obstructive pulmonary disease based on smoking, because Dr. Hasson "was not aware" that radiographic evidence of pneumoconiosis existed (DX 35 at 6). It appears, however, that ALJ Tierney mistakenly inferred that Dr. Hasson's conclusion that there was "no

[8] The form did not cite the source for the Claimant's counsel's source of this information on the Claimant's job duties.

[9] Dr. Hasson's report reflects a smoking history of 45 years at 1 to 3 pack per day, for a total of 45-135 pack years; Dr. Hawkins' report reflects a smoking history from age 17 (1953 approximately) to 2002 of 1 to 3 packs per day, for a total of 50-150 pack years.

evidence" of pneumoconiosis equated to a rejection of the possibility that pneumoconiosis existed.

Had ALJ Tierney not erred in his characterization of these physicians' opinions, he likely would have weighed both Dr. Hasson's and Dr. Hawkins' opinions in light of the evidence of the Claimant's smoking history, rather than discounting Dr. Hasson's conclusions and relying so heavily on Dr. Hawkins' opinion. Consequently, I find that there exists a mistake in determination of fact in ALJ Tierney's Decision, thus permitting a re-examination of the entirety of evidence presented. See Jessee v. Director, OWCP, 5 F.3d 723 (4th Cir. 1993).

As I find that the prior determination contains mistakes in determination of fact, I shall now examine the current record in light of the newly submitted evidence, to determine whether the request for modification should be granted on the basis of that mistake in determination of a fact, or on the basis of a change in a condition of entitlement, or whether, upon review of the new evidence, ALJ Tierney's award of benefits should stand. Zurat, supra.

2. Elements of Entitlement

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, § 718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

(1) X-ray evidence: § 718.202(a)(1).
(2) Biopsy or autopsy evidence: § 718.202(a)(2).
(3) Regulatory presumptions: § 718.202(a)(3).[10]

[10] These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§ 718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is

(4) Physician opinion based upon objective medical evidence: § 718.202(a)(4).

1) X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

The current record contains the following chest X-ray evidence:

Date of X-Ray	Date Read	Ex. No.	Physician	Radiological Credentials[11]	Interpretation
08/27/2002	08/30/2002	DX 10	Ballard	BCR, B[12]	1/0; s; t; lower four lung zones
08/27/2002	03/03/2003	DX 31	Ahmed	BCR, B	1/0; p, s; all six lung zones
03/04/2004	Not listed[13]	EX 1	Hasson	Unclear [14]	0/0; "no evidence of pneumoconiosis"

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other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§ 718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§ 718.306).

[11] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. § 37.51 for a general description of the B reader program.

[12] After a search of the record, I was unable to locate a curriculum vitae for Dr. Ballard. Per my pre-hearing order, I confirmed his credentials using the Internet. See http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html; see also http://www.abms.org.

[13] Dr. Hasson's reading is included as a narrative summary in his medical opinion report. I find that Dr. Hasson's X-ray interpretation is in "substantial compliance" with the quality standards of the ILO-UICC classification system. See § 718.102; Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79,929 (Dec. 20, 2000).

[14] After a search of the record, I was unable to locate a curriculum vitae or other listing of Dr. Hasson's credentials. I note that, on its pre-hearing statement, the Employer lists Dr. Hasson as a Board certified radiologist, and B reader; that Dr. Hasson's letterhead states that his practice group, Princeton Pulmonary Group, practices internal medicine, critical care medicine, pulmonary medicine, and sleep disorders; and that ALJ Tierney's decision lists him as a B

08/14/2006	08/14/2006	EX 4	Goldstein	B	Negative
08/14/2006	10/16/2006	CX 3	Miller	BCR, B	1/1; t, q; all six lung zones

* The gray shading is used to distinguish those pieces of evidence that were before ALJ Tierney as well. The unshaded area includes the evidence that is newly presented before me.

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

Where two or more X-ray reports conflict, consideration shall be given to the radiological credentials of the physicians interpreting the X-rays. § 718.202(a)(1). It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 537 (1983). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

For the purpose of determining the X-ray evidence, I give more weight to the opinions of physicians who are Board-certified radiologists and B readers than I do to the opinions of physicians who are not Board-certified radiologists but are B readers. I give more weight to the opinions of the former because they have wide professional training in all aspects of X-ray interpretation. I give equal weight to all physicians who possess the same professional credentials (for example, all Board-certified radiologists).

As listed above, the record contains five X-ray interpretations: two interpretations of an X-ray taken in August 2002; one interpretation of an X-ray taken in March 2004; two interpretations of an X-ray taken in August 2006.

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reader. Relevant websites stated the following: the American Board of Medical Specialties website lists him as certified in internal medicine, with subspecialties in critical care and pulmonary disease; the CDC/NIOSH website does not list him as a certified B reader.

The August 2002 X-ray was interpreted as positive for pneumoconiosis by two dually-qualified physicians, Dr. Ballard and Dr. Ahmed. The March 2004 X-ray was interpreted as negative by Dr. Hasson, whose credentials are unclear. There is conflict regarding the August 2006 X-ray. Dr. Goldstein interpreted the X-ray as negative, while Dr. Miller found it to be positive. However, Dr. Miller is dually qualified as a Board certified radiologist as well as a B reader, while Dr. Goldstein is certified as a B reader only. Therefore, in light of Dr. Miller's more impressive credentials, I give more weight to his interpretation of the X-ray as positive for pneumoconiosis. I note also that this is the most recent X-ray of record.

Based on the totality of the X-ray evidence discussed above, I find that pneumoconiosis is established by X-ray.

2) Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). Section 718.106 sets forth the quality standards for autopsies and biopsies. Further, the Benefits Review Board has held that "anthracosis found in lymph nodes may be sufficient to establish the existence of pneumoconiosis." Taylor v. Director, OWCP, No. 01-0837 B.L.A. (B.R.B: July 30, 2002) (unpublished). However, the Board has also held that "a finding on autopsy or biopsy of anthracotic pigmentation shall not be sufficient, by itself, to establish the existence of pneumoconiosis." Hapney v. Peabody Coal Co., No. 000-0336 B.L.A (June 29, 2001)(en banc).

The record includes a surgical pathology report, which was also submitted before ALJ Tierney (DX 31). No new biopsy evidence was submitted upon modification.

The pathology report, written by Dr. Katrin Klemm, was performed on the left lung lymph nodes, and it describes findings such as "benign pleura with fibrosis;" "benign lung parenchyma with focal anthracosilicotic nodule;" "pigmented nodule with polarizable material, morphologically consistent with anthracosilicotic nodule." I find that this report is sufficient to establish pneumoconiosis by biopsy.

3) Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions applies in this case, pneumoconiosis is not established under § 718.202(a)(3).

4) Physician Opinion

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following medical opinions on the existence of pneumoconiosis:

Dr. Jeffrey Hawkins (DX 10, 31; CX 4)

As discussed above, in August 2002, Dr. Hawkins performed the OWCP evaluation of the Claimant (DX 10). Dr. Hawkins is Board certified in internal medicine with subspecialties in pulmonary medicine and critical care medicine (DX 31). Dr. Hawkins' report was also before ALJ Tierney.

In conjunction with the evaluation, Dr. Hawkins took a medical history and attached the Claimant's Employment history form CM 911; performed a physical examination; and reviewed a pulmonary function test, arterial blood gas study, and chest X-ray interpretation. He recorded the Claimant's smoking history as follows: the Claimant started smoking at age 17, and stopped smoking in June 2002; he smoked one to three packs of cigarettes per day.

Upon physical examination of the thorax and lungs, Dr. Hawkins noted symmetry upon inspection and "no lesions;" palpitation was "not tender;" percussion showed "no dullness;" and auscultation was "clear/mildly reduced."

Dr. Hawkins diagnosed the Claimant with the following: cardiomyopathy based on "CWP ? illegible ABG," "ABN ?illegible VCG" and "exertional dyspnea;" and pneumoconiosis based on "exposure history to coal dust," "exertional dyspnea," "mild reduction FVC," "ABN CXR/compatible," "recent lung biopsy showing anthrosilicotic nodules."

In September 2006, Dr. Hawkins reviewed his August 2002 evaluation of the Claimant, and also reviewed the opinion of Dr. Rosenberg from January 2005, and Dr. Goldstein from August 2006, and submitted a statement, which, in its entirety, read as follows:

> I have reviewed my evaluation of [the Claimant] on August 27, 2002 and subsequent opinions of Dr. Rosenberg (January 11, 2005) and Dr. Goldstein (August 14, 2006). Nothing in their evaluations changes my earlier opinion in this case (CX 4).

Dr. Jack Hasson (EX 1)

The Employer submitted a report written by Dr. Jack Hasson.[15] Dr. Hasson examined the Claimant in March 2004; his examination included performing a physical examination, reviewing a chest X-ray, and taking a pulmonary function test and arterial blood gas test, as well as recording the Claimant's work and medical history. Dr. Hasson's report was also before ALJ Tierney.

Concerning the Claimant's work history, Dr. Hasson recorded that the Claimant had a work history of 18 ½ years as a underground coal miner, and also worked "on the top;" he listed the Claimant's job as including mechanic, electrician, rock man helper, general inside labor, and shuttle car operator. Concerning the Claimant's smoking history, Dr. Hasson recorded that the Claimant smoked one to three packs of cigarettes per day for 45 years, and stopped smoking in 2002.

Upon physical examination, particularly of the chest area, Dr. Hasson stated that "Chest exam demonstrates symmetrical expansion of the lungs bilaterally, with no use of accessory muscles. Tactile fremitus was increased bilaterally. Lungs were hyperresonant to percussion, with decreased breath sounds and an expiratory delay with end expiratory wheezes bilaterally." Dr. Hasson also stated that "Spirometry reveals a mild obstructive ventilatory impairment," and that the Claimant had "Mild hypoxemia with hyperventilation at rest." The chest X-ray was negative for pneumoconiosis, but was "consistent with chronic obstructive pulmonary disease."

In conclusion, Dr. Hasson stated:

> The patient has a moderate pulmonary impairment based on his exercise study, his exam, and PFTs, and this is related to chronic obstructive pulmonary disease. There is no evidence of pneumoconiosis. The patient has a history of coronary artery disease and this may indeed contribute to his problem with dyspnea, but his dyspnea is predominantly related to his chronic obstructive pulmonary disease and his chronic obstructive pulmonary disease is related to his smoking.

Dr. David Rosenberg (EX 2, 3)

At the request of the Employer, Dr. Rosenberg prepared a report of his findings in January 2005, after reviewing several documents including treatment records, and examination records produced in conjunction with the Claimant's claim, such as Dr. Hasson's 2004

[15] See id. for a discussion of Dr. Hasson's credentials.

evaluation, Dr. Hawkins' 2002 evaluation, and an evaluation by Dr. Goldstein performed in 1997; and chest X-ray interpretations of Dr. Ahmed, Dr. Goldstein, and Dr. Ballard (EX 2). Dr. Rosenberg is Board certified in internal medicine, pulmonary disease, and occupational medicine (EX 3). Dr. Rosenberg's report was not before ALJ Tierney.

After reviewing and summarizing the individual documents, Dr. Rosenberg described the Claimant's condition as follows:

> In summary, [the Claimant] is a 68 year old gentleman with probably over 30 years of coal mining employment and he has a long smoking history throughout most of his adult life, with a history of coronary artery disease, having had bypass surgery. He also has a history of pneumothorax requiring chest tube insertion, and various respiratory symptoms were described. His pulmonary function tests when performed with good effort revealed no obstruction or restriction, and generally his blood gases until recently have been well preserved, without gas exchange abnormalities even with exercise. Overall, his chest X-rays and CAT scan have not demonstrated micronodularity, with some irregularity being present; a lung biopsy performed to exclude a tumor revealed some anthrasilicosis….
>
> In conclusion, it can be stated with a reasonable degree of medical certainty, the clinical diagnosis of CWP cannot be established in [the Claimant]. He potentially has some pathologic evidence of minimal simple CWP. While he has no significant impairment related to his coal mining employment, recently, he was demonstrated to have a disabling gas exchange abnormality. However, this does not relate to the presence of CWP or past coal dust exposure.

Dr. Allan Goldstein (EX 4, 5)

At the request of the Employer, Dr. Goldstein examined the Claimant in August 2006, and wrote a medical report stating his conclusions. His examination included a chest X-ray, pulmonary function test, and arterial blood gas test; he also took a medical and work history (EX 4). Dr. Goldstein is Board certified in internal medicine and pulmonary disease; he is also a certified B reader (EX 5). Dr. Goldstein's report was not before ALJ Tierney.

Concerning the Claimant's work history, Dr. Goldstein recorded that the Claimant worked in coal mining from 1968 until 1994, and that he retired after bypass surgery. Dr. Goldstein also stated the following regarding the Claimant: "He worked underground all but the last two to three years. He worked as an electrician, repairman, shuttle car operator and rock man helper. When he worked aboveground he worked as a repairman at the washer. He was exposed to coal dust, rock dust and diesel fumes, and as far as he knows was not exposed to any asbestos. There is no other history of any toxic exposure."

Concerning his smoking history, Dr. Goldstein recorded that, as of the time of his examination, the Claimant had not smoked for 18 months, but prior to that, he "smoked forty-five to fifty years at, at least, a pack of cigarettes per day."

Upon physical examination, Dr. Goldstein made the following observations about the Claimant's chest: "Hyperresonant with increased AP diameter. Markedly decreased breath sounds without rhonchi, wheezes or rales."

In conclusion, Dr. Goldstein stated the following:

> [The Claimant has] a history of coronary artery disease with bypass on two occasion, shortness of breath since the 1980's that has progressed, forty-five-to-fifty-pack-year-history of smoking, lung cancer with resection of the left upper lobe, chest x-ray consistent with COPD, pulmonary functions consistent with an obstructive defect, and a physical examination consistent with an obstructive defect. The patient was not exercised because of his shortness of breath that he describes with activity and the fact that his cardiologist did not feel that exercise should be done on him.
>
> It is my impression that this man has COPD and lung cancer secondary to smoking. He has had coronary artery disease with bypass surgery. I do not believe that his findings are consistent with occupational pneumoconiosis. His chest x-ray does not show any nodular infiltrates suggestive of coal nodules.

Discussion

The record contains four physician opinions on the existence of pneumoconiosis: one physician, Dr. Hawkins, opined that the Claimant had pneumoconiosis; two physicians, Dr. Hasson and Dr. Goldstein, opined that the Claimant did not have pneumoconiosis; and one physician, Dr. Rosenberg, was equivocal.

I find that Dr. Hawkins was of the opinion that the Claimant had both cardiomyopathy and pneumoconiosis. He made this diagnosis after examining the Claimant, and reviewing his objective tests. While Dr. Hawkins did not discuss X-ray explicitly as a basis for his diagnosis of pneumoconiosis, he did list that he reviewed and relied upon a positive X-ray interpretation in forming his opinion. However, I have already found that the X-ray evidence establishes pneumoconiosis, and therefore, I find that this reliance adds credence to his opinion. Regarding the substance of Dr. Hawkins' opinion, I found that, while he stated the basis for his opinion, his rationale was not explained in detail. Although I would have appreciated the opportunity to review a more thorough opinion from Dr. Hawkins, I do not discount his opinion because it is less than complete, but I do give it less weight.

Dr. Hasson however, opined that the Claimant did have COPD owing to smoking, and also stated that there was no evidence of pneumoconiosis. In forming his opinion, Dr. Hasson considered the chest X-ray, which he found negative for pneumoconiosis. As discussed above, I

found that the X-ray evidence demonstrated pneumoconiosis, and I therefore give less weight to his opinion.[16]

While Dr. Rosenberg acknowledged pathologic evidence of "minimal simple CWP," he did not diagnose the Claimant with pneumoconiosis. However, while he discussed his familiarity with the pathologic evidence, he did not discuss how, despite that evidence, he reached his conclusion that the Claimant did not have pneumoconiosis. I therefore find his opinion not well reasoned in this regard, and I give it less weight.

Dr. Goldstein opined that the Claimant had COPD owing to smoking, and did not have pneumoconiosis. His opinion was based in part on chest X-ray, as Dr. Goldstein's interpretation of the X-ray he read was that it was "consistent with COPD," but not consistent with occupational pneumoconiosis as the X-ray did "not show any nodular infiltrates suggestive of coal nodules."

Dr. Hasson, Dr. Rosenberg and Dr. Goldstein based their opinions, at least in part, on the negative interpretation of X-rays. However, as discussed above, I found that the X-ray evidence establishes pneumoconiosis. Therefore, on that basis, I give little weight to their opinions.

While the physician opinion evidence does not point clearly towards a finding of either "clinical" or "legal" pneumoconiosis, as the opinion evidence did not clearly differentiate between the two, I have already found that the Claimant has established pneumoconiosis based on X-ray and biopsy evidence.[17]

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b). However, where a miner has established less than ten years of coal mine employment history, "it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship." § 718.203(c).

In this case, the parties stipulated to 18 ½ years of coal mine employment at the hearing before ALJ Tierney (DX 32 at 8). Therefore, the Claimant is entitled to the rebuttable presumption that his pneumoconiosis arose out of his coal mine employment. The Employer has not presented any evidence to rebut this presumption, therefore, I find (as did ALJ Tierney) that the Claimant's pneumoconiosis arose out of his coal mine employment.

[16] However, the particular X-ray that Dr. Hasson read was uncontested—the record contains no other physician interpretation of this X-ray.

[17] Therefore, I find that the Claimant has established that he has pneumoconiosis, specifically "clinical" pneumoconiosis only, and that, in this regard, ALJ Tierney's decision was not based on a mistake in determination of fact.[17]

C. Whether the Claimant is Totally Disabled

The Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment . . . requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. § 718.204(a). See also Beatty v. Danri Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv)

1) Pulmonary Function Tests

A Claimant may establish total disability based upon pulmonary function tests. In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [FEV_1] test and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the FEV_1 divided by the FVC that is less than or equal to 55%. § 718.204(b)(2)(i). "Qualifying values" for the FEV_1, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The record contains the following pulmonary function test results:

Date of Test	Physician	Height	Age	FEV_1	FVC	MVV	FEV_1/FVC ratio	Valid ?
08/27/2002	Hawkins	65 in.	66	2.26	2.80	102	81	Yes
03/10/2004	Hasson	65 in.	67	1.89	2.84	49	67	Yes
08/14/2006	Goldstein	65 in.	70	1.84/1.91*	2.51/2.52	64/67	73/76	Yes

* The second set of numbers represents results after bronchodilator.

** The gray shading is used to distinguish those pieces of evidence that were before ALJ Tierney. The unshaded area includes the evidence that is newly presented before me.

In all three tests, the Claimant's height was listed at 65 inches; I find that he is 65 inches tall. For a 66 year old male, who is 65 inches tall, the qualifying FEV_1 value is 1.56, the qualifying FVC value is 2.01, and the qualifying MVV value is 62. For a 67 year old male, at 65 inches tall, the qualifying FEV_1 value is 1.54, the qualifying FVC value is 1.99, and the qualifying MVV value is 62. For a 70 year old male, at 65 inches tall, the qualifying FEV_1 value is 1.49, the qualifying FVC value is 1.94, and the qualifying MVV value is 60.

None of the pulmonary function test results were qualifying. Therefore, I find that total disability is not established under this provision.[18]

2) Arterial Blood Gas Tests

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO_2] and percentage of oxygen [PO_2], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and PCO_2 level, a qualifying value must be less than or equivalent to the PO_2 listed in the table.

The record contains the following arterial blood gas test results:

Date of Test	Physician	PCO_2	PO_2	PCO_2 (post-exercise)	PO_2 (post-exercise)	Altitude
08/27/2002	Hawkins	30	102	32	97	0-2999 ft
03/10/2004	Hasson	31	74.6	28.3	62.8	Not listed [19]
08/14/2006	Goldstein	36	83	N/A*	N/A*	Not listed [20]

* Post-exercise trials not performed.

** The gray shading is used to distinguish those pieces of evidence that were before ALJ Tierney as well. The unshaded area includes the evidence that is newly presented before me.

For a PCO_2 value of 29, at an altitude of 2999 feet or less, the qualifying PO_2 value must be equal to or less than 71. For a PCO_2 value of 30, at an altitude of 2999 feet or less, the qualifying PO_2 value must be equal to or less than 70. For a PCO_2 value of 31, at an altitude of 2999 feet or less, the qualifying PO_2 value must be equal to or less than 69. For a PCO_2 value of

[18] However, I note that in examining the post-bronchodilator test performed by Dr. Goldstein, I observed that the Claimant's test results did not change significantly after bronchodilator. I note that this evidence may be inconsistent with Dr. Goldstein's opinion, which states that the Claimant's impairment is due to smoking, and which is discussed below in the section on physician opinion concerning total disability. See Consolidation Coal Co. v. Swiger, 98 Fed.Appx. 227 (4th Cir. 2004)(unpub.).

[19] Per 29 C.F.R. § 18.201, judicial notice may be taken of adjudicative facts. The highest point in Alabama is 2,407 feet. See http://geology.com/states/alabama.shtml.

[20] See id.

32, at an altitude of 2999 feet or less, the qualifying PO_2 value must be equal to or less than 68. For a PCO_2 value of 36, at an altitude of 2999 feet or less, the qualifying PO_2 value must be equal to or less than 64.

The arterial blood gas tests yielded one qualifying result, in the March 2004 test performed in conjunction with Dr. Hasson's exam. However, this one result is inconsistent with the entirety of the remaining evidence. All of the other tests, including the most recent test by Dr. Goldstein, produced non-qualifying results. Therefore, I find that total disability is not established under this provision.

3) Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). However, in the Claimant's case, there is no evidence of cor pulmonale with right-sided congestive heart failure. Accordingly, I find that total disability may not be established under this provision.

4) Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989). A physician's opinion must demonstrate an adequate understanding of the exertional requirements of the Claimant's coal mine employment. Brigance v. Peabody Coal Co., B.R.B. No. 05-0722 B.L.A. (June 29, 2006)(en banc).

The record contains the following physician opinions on the issue of disability:

Dr. Hawkins (DX 10, 31; CX 4)

Dr. Hawkins diagnosed the Claimant with a mild/moderate impairment, stating that the Claimant "cannot perform manual labor," that he has exertional dyspnea, and that he "should avoid further exposure to chemicals, dust." Dr. Hawkins attributed 40% of the Claimant's impairment to pneumoconiosis, and attributed the other 60% to cardiomyopathy (DX 10).

On a prepared form dated January 30, 2003, Dr. Hawkins checked one of several options to describe his opinion of the Claimant's respiratory capacity; his opinion was that the Claimant "does not have the respiratory capacity to perform the job of electrician/repairman, but I believe

this impairment is caused by both other factors and exposure to coal and rock dust during his employment" (DX 31).

As stated earlier, Dr. Hawkins wrote a supplemental opinion in September 2006, after he reviewed his August 2002 evaluation of the Claimant, the opinion of Dr. Rosenberg from January 2005, and the opinion of Dr. Goldstein from August 2006. Dr. Hawkins stated that "[n]othing in their evaluations changes [his] earlier opinion in this case" (CX 4).

Dr. Hasson (EX 1)

As stated above, Dr. Hasson opined that the Claimant "has a moderate pulmonary impairment based on his exercise study, his exam, and PFTs, and this is related to chronic obstructive pulmonary disease …. his dyspnea is predominantly related to his chronic obstructive pulmonary disease and his chronic obstructive pulmonary disease is related to his cigarette smoking."

Dr. Rosenberg (EX 2, 3)

Dr. Rosenberg stated the following concerning whether the Claimant had a pulmonary impairment:

> … [I]t can be appreciated from a pulmonary functional perspective, [the Claimant] does not have restriction, with his FVC being normal when spirometry is performed with good effort. Also, on auscultation of his chest, his lung fields are clear, without the presence of chronic end-inspiratory rales….
>
> From a functional perspective, [the Claimant] has no significant obstruction or restriction, with normal gas exchange on exercise through 2002. More recently, his PO_2 was somewhat reduced at rest and fell with exertion to disabling levels, the degree of which would prevent him from performing his previous coal mining job or similarly arduous types of labor. Undoubtedly, this gas exchange abnormality relates to his long (up to 150 pack-years) and continued (elevated carboxyhemoglobin level noted as of 2002) smoking history. Also, smoking causes the type of low grade linear interstitial changes (e.g. bronchoiolitis interstitial lung disease) [the Claimant] is reported to have. If indeed [the Claimant] has a minimal degree of simple CWP, it is not causing of contributing to a fall in PO_2, which in fact wasn't present in 2002….
>
> While [the Claimant] has no significant impairment related to his coal mining employment, recently, he was demonstrated to have a disabling gas exchange abnormality. However, this does not relate to the presence of CWP or past coal dust exposure.

Dr. Goldstein (EX 4, 5)

As stated above, Dr. Goldstein discussed the Claimant's condition and his medical history, and he stated explicitly his opinion that the Claimant had pulmonary function and physical examination "consistent with an obstructive defect," "COPD and lung cancer secondary to smoking," and that his condition was not "consistent with occupational pneumoconiosis." However, he did not opine specifically concerning the Claimant's level of disability.

Discussion

The record contains several physician opinions on the issue of disability. Of those who opined explicitly on the matter, namely Dr. Hawkins, Dr. Hasson, and Dr. Rosenberg, the consensus is that the Claimant has a respiratory or pulmonary impairment.

Dr. Hawkins opined that the Claimant had a "mild/moderate impairment" and that he "cannot perform manual labor."[21] In an additional report dated January 30, 2003, Dr. Hawkins opined that the Claimant did not have the respiratory capacity to perform his last coal mine job. He made this assessment based on the following information: 1) the non-qualifying pulmonary function study and arterial blood gas study; and 2) the exertional requirements of the Claimant's job of electrician/repairman. Dr. Hasson opined that the Claimant had a "moderate pulmonary impairment" due to COPD, which itself was related to cigarette smoking. Dr. Hasson made this assessment based on his physical examination of the Claimant, and the Claimant's arterial blood gas exercise study and pulmonary function test. Dr. Rosenberg opined that, after reviewing the Claimant's recent blood gas study that produced disabling values on exertion, this test demonstrated that the Claimant had a disability, "the degree of which would prevent him from performing his previous coal mining job or similarly arduous types of labor." Finally, while Dr. Goldstein opined that the Claimant's pulmonary function testing and physical examination was "consistent with an obstructive defect" and "COPD and lung cancer," he did not state explicitly whether he had an opinion on whether the Claimant has a respiratory or pulmonary impairment, or on the existence, and extent, of a disability.

After considering the consensus of the opinions, I find that the Claimant has at least a mild-moderate level of impairment. Further, after considering the explicit statements on the matter from Dr. Hawkins and Dr. Rosenberg, I find that this level of impairment leaves the Claimant unable to perform the exertional requirements of his last coal mine job. In making my determination, I weighed these opinions in light of the evidence of record, particularly the transcript of the hearing before ALJ Tierney, which concerned the exertional requirements of the Claimant's last coal mine employment. At that hearing, the Claimant stated that his last coal mine employment as a repairmen required lifting motors that were "75 to 100 pounds," "carry around about a 40 pound tool pouch all the time," spending "two hours up and down the stairs, maybe three sometimes," crawling and stooping, shoveling, and hammering with a six pound hammer (T. at 18-20).

[21] Dr. Hawkins' assessment was made based on his OWCP evaluation of the Claimant, which was also submitted as evidence to ALJ Tierney. However, Dr. Hawkins also stated, in a rehabilitative report submitted by the Claimant as evidence in the modification claim, that his opinion was unchanged.

Therefore, based on the foregoing, I find that the Claimant has established, by a preponderance of the evidence, that he is totally disabled due to a respiratory or pulmonary condition.

d. Whether the Claimant's Disability is Due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. § 718.204(c); Lollar v. Alabama By-Products Corp., 893 F.2d 1258 (11th Cir. 1990). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. In general, the fact that an individual suffers or suffered from a totally disabling respiratory or pulmonary impairment is not, in itself, sufficient to establish that the impairment is or was due to pneumoconiosis. § 718.204(c)(2). A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c).

As discussed above, I have found that the Claimant established both that he has pneumoconiosis arising out of coal mine employment, and that he is totally disabled from his last coal mine job based on a respiratory or pulmonary impairment. Although the opining physicians agreed that the Claimant had some respiratory or pulmonary impairment, only Dr. Hawkins attributed any part of this impairment to pneumoconiosis; Dr. Hasson and Dr. Rosenberg attributed this impairment to other causes, most particularly the Claimant's smoking history. However, I underscore that both of these physicians opined that the Claimant did not have evidence of pneumoconiosis, while I found that the record did establish pneumoconiosis. Therefore, I can give only little weight to their opinion on the issue of causation of the Claimant's impairment, as neither of them considered whether pneumoconiosis was a cause.

I am left with the opinion of Dr. Hawkins, who opined both that the Claimant had pneumoconiosis, and that his totally disabling impairment was due, at least in part, to the pneumoconiosis. Upon my review of Dr. Hawkins' opinion, I find that it was not well reasoned nor well documented because Dr. Hawkins failed to address an important risk factor in his opinion of disability causation, particularly, the Claimant's smoking history.[22] Dr. Hawkins was

[22] In addition to opining that the Claimant's disability was due in part to pneumoconiosis, Dr. Hawkins found that the Claimant's disability was due also to cardiomyopathy, a heart condition. Although the link between smoking and heart problems is well established, and although Dr. Hawkins was aware of the Claimant's smoking history, he did not address whether smoking may have played a role in causing the Claimant's disabling heart condition. Per 29 C.F.R. § 18.201, judicial notice may be taken of adjudicative facts. People have a higher risk of developing cardiomyopathy if they have a personal history of smoking. See http://www.nlm.nih.gov/medlineplus/ency/article/000170.htm#Causes,%20incidence,%20and%20risk%20factors.

not clear how, if at all, the Claimant's cardiomyopathy, which he stated was the primary cause of the Claimant's disability, related to his smoking history. Given the record, particularly the Claimant's smoking history, which Dr. Hawkins related on the OWCP evaluation form, and given that the other opining physicians attributed the Claimant's impairment to his cigarette smoking, I find that Dr. Hawkins' failure to address smoking as a possible cause of the Claimant's impairment made his opinion incomplete. Due to Dr. Hawkins' failure to discuss the Claimant's cigarette smoking as a potential cause of his impairment, I find that his opinion is not sufficiently credible, and I therefore give it less weight.

After weighing the physician opinions that attributed the Claimant's impairment to smoking (and that discounted pneumoconiosis) against the physician opinion that attributed a portion of the Claimant's impairment to pneumoconiosis (and that did not discuss smoking), I find that none of the opinions are sufficiently credible upon which to base a finding concerning the cause of the Claimant's totally disabling pulmonary or respiratory impairment.

I make this finding in light of the Department of Labor's position that tobacco smoking and coal mining can both cause pulmonary impairment, and that the effects of both of these factors are additive. See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920, 79,940-41 (Dec. 20, 2000). Therefore, while I found that the Claimant has pneumoconiosis and also has a totally disabling pulmonary or respiratory condition, I am not able to find a causative relationship between the two conditions, based on the evidence before me. Regarding ALJ Tierney's decision, I find that his determination, that the Claimant's totally disability was due to pneumoconiosis, was based entirely on Dr. Hawkins' opinion. As noted above, I have found that ALJ Tierney made a mistake in determination of fact when he assessed Dr. Hawkins' opinion. As I discussed above, I find that Dr. Hawkins' opinion was neither well reasoned nor well documented.

Notably, none of the new evidence that the Employer submitted in this request for reconsideration is inconsistent with the evidence, previously submitted, regarding the extent of the Claimant's disabling pulmonary impairment. The Employer's new evidence, rather, relates to the etiology of the Claimant's disability, and uniformly asserts that the Claimant's impairment is due exclusively, or primarily, to the Claimant's smoking habit.

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established his entitlement to benefits under the Act. Further, I find that there were mistakes in determinations of fact in the prior adjudication of this Claim.

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

The Claimant's Claim for benefits under the Act is DENIED.

A

Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).